INSTRUCTIONS
DSL-2493
Referral for Pre-Admission Consultation Form

These instructions are formatted to follow the Referral for Pre-admission Consultation Form. Please use these instructions to assist in filling out each line on the form.

Name of Facility Making Referral: This line should contain the name of the hospital, residential care apartment complex, community based residential facility, adult family home or nursing facility that is making the referral for Pre-admission Consultation to the Resource Center.

Street Address, City, State and Zip: This line should contain the complete address of the facility that is making the referral for Pre-admission Consultation to the Resource Center. If a hospital is making the referral these fields should contain the hospital's complete address. The second section on this form allows the hospital to provide the name and address of the facility that the resident is being transferred to upon discharge.

Contact Person: This line should contain the name of the discharge planner at the hospital or the admissions planner for the facility making the referral.

Telephone Number: This line should contain the telephone number of this contact person at the hospital or facility making the referral.

Name of Person Referred (Last, First, Middle): This line should contain the complete name (last, first, middle) of the person being referred to the Resource Center.

Date of Birth: This line should contain the date of birth of the person being referred to the Resource Center.

Permanent Residence (Street, City, State and Zip): This line should contain the complete address where the person being referred usually lives/resides.

Social Security Number: If the facility has access to the SSN and/or the person being referred is willing to provide his/her SSN it should be entered on this line. The SSN is an important piece of information and should be collected whenever possible. It will be kept confidential.

Telephone Number: This line should contain the telephone number for the permanent residence of the person being referred to the Resource Center.

Date of Referral: This line should contain the date that the facility filled out the referral form and sent it to the Resource Center.

County of Residence: This line should contain the name of the County in which the referred person's permanent residence is located.

Name of Temporary or Current Location (if not at permanent residence; i.e., hospital, CBRF, etc.): This line should contain the name of the facility (i.e., hospital, CBRF, etc..) or residence where the person being referred is temporarily staying if different than permanent residence indicated above.

Telephone Number of Current or Temporary Location: This line should contain the telephone number of the temporary or current location of the person being referred.

*****Providing the Information in this Section is Optional, if Known*****

Name of Person Who Contacted the Facility (if different from the referred person): If the person who contacted the facility is someone other than the person being referred to the Resource Center, this line should contain that person's full name.

Relationship to Referred Person: This line should contain the relationship that exists between the person who actually contacted the facility and the person being referred to the Resource Center (i.e., parent, spouse, son/daughter, etc….).

Telephone Number: This line should contain the telephone number of the person who contacted the facility (if different from than the referred person).

Name of Guardian or Activated Power of Attorney for Health Care: This line should contain the name of the Guardian or Activated Power of Attorney for Health Care, if known. If a name is listed then please check the appropriate box (Guardian or POAHC) on the same line.

Street Address, City, State and Zip: This line should contain the complete address of the person listed as Guardian or Activated Power of Attorney for the person being referred to the Resource Center.

Telephone Number: This line should contain the telephone number of the person listed as Guardian or Activated Power of Attorney for the person being referred to the Resource Center.

Name of Resource Center: This line should contain the name of the Resource Center to which this referral for pre-admission for consultation is being sent.

Address (City, State and Zip): This line should contain the address of the Resource Center to which this referral for pre-admission consultation is being sent.

Name of Facility Resident Will Be Transferred to Upon Discharge: This line should only be filled out by a hospital making a referral. It should contain the name of the facility that resident will be transferred to upon discharge from the hospital.

Street Address, City, State and Zip: This line should contain the address of the facility that the resident will be transferred to upon discharge from the hospital.

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Supportive Living
DSL-2493 (1-00)

REFERRAL FOR PRE-ADMISSION CONSULTATION
(Print this form on blue paper)

Completion of this form is not mandatory, however, this form can be used to document the referral to a Resource Center as required by ss. 50.033(2s), .034(5n), .035(4n), .40(2h) and .36(2)(c), Wis. Stats. Provision of the referred person's Social Security Number is voluntary. This form is for use by hospital discharge planners and admissions staff of residential care apartment complexes, community residential care facilities, adult family homes and nursing facilities. Complete and submit a **COPY** of this form to the Resource Center. Maintain the **ORIGINAL** copy of this form, **PRINTED ON BLUE PAPER,** in the resident's file upon admission.

Name of Facility Making Referral

Street Address, City, State and Zip

Contact Person	Telephone Number ( )
Name of Person Referred (Last, First, Middle)	Date of Birth
Permanent Residence (Street, City, State, and Zip)	Social Security Number

Telephone Number ( )	Date of Referral	County of Residence

INDICATE BELOW WHERE THE PERSON WHO IS BEING REFERRED CAN BE REACHED IN THE NEXT 5 WORKING DAYS IF NOT AT THE PERMANENT RESIDENCE

Name of Temporary or Current Location (if not at permanent residence; i.e., hospital, CBRF, etc.)	Telephone Number of Current or Temporary Location

PROVIDING THE FOLLOWING INFORMATION IS OPTIONAL, IF KNOWN

Name of Person Who Contacted the Facility (if different from the referred person)

Relationship to Referred Person	Telephone Number ( )
Name of Guardian or Activated Power of Attorney for Health Care	(CHECK ONE) ☐ GUARDIAN ☐ POAHC
Street Address, City, State and Zip	Telephone Number ( )

Name of Resource Center

Address (City, State and Zip)

IF A HOSPITAL IS MAKING THE REFERRAL, COMPLETE THE FOLLOWING ADDITIONAL INFORMATION

Name of Facility Resident Will Be Transferred to Upon Discharge

Street Address, City, State and Zip

(ORIGNAL COPY OF THIS FORM PRINTED ON BLUE PAPER REMAINS AT FACILITY) **(WHITE PHOTOCOPY TO RESOURCE CENTER)**